Regional EMS Council Process Action Team Meeting
Fredericksburg Hospitality House & Conference Center
Fredericksburg, Virginia
June 3, 2008
8:30 a.m.

Members Present:	Members Absent:	OEMS Staff:	Others:
Gary P. Critzer, EMS Council Board President, PAT Chair		Scott Winston	Bill Downs, TJEMS
Dr. Rob Logan, EMS Council Executive Director		Wanda Street	Jeff Meyer, PEMS
Tina Skinner, EMS Council Executive Director		Michael D. Berg	Connie Purvis, BREMS
Dr. Scott Weir, Operational Medical Director		Dennis Molnar	David Cullen, CSEMS
Dr. Theresa Guins, Physician Member of EMS Advisory Board			Byron Andrews, NVEMSC
Donna Burns, EMS Council Board President			Tracey McLaurin, LFEMS
Dreama Chandler, VAVRS President			Melinda Duncan, NVEMSC
Randy Abernathy, VAGEMSA President			Gregory Woods, SVEMS
Chris Eudailey, Virginia Fire Chief's Assoc. Representative			Tracy Thomas, ODEMSA
Scott Hudson, Rural Based EMS Service Representative			Linda Hale, Loudoun Co. Fire and Rescue
Bruce Edwards, EMS Advisory Board Member			Ray Whatley, NVEMSC/Alexandria Fire Dept.
Jason Campbell, Virginia Professional Fire Fighter/VML Representative			Carlton Burkhammer, Fairfax Co. Fire & Rescue
Dr. Jack Potter, Designated Trauma Center Representative			Byron Andrews, NVEMSC
Gary R. Brown, OEMS Director			
Dr. Lisa Kaplowitz, Virginia Department of Health (ex-officio member)			
Tim Perkins, OEMS Staff to PAT			
Jerry Overton, Urban Based EMS Service Representative			

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
Call to Order:	The meeting was called to order by the chair, Mr. Gary Critzer, at 8:31 a.m.	
Review & Approval of the minutes dated April 29, 2008:	A motion was made and seconded to approve the minutes with the appropriate changes to clarify the "I's" and "We's" under the section where Tim Perkins gave his responses to previous questions. Gary Brown stated that those comments were Tim's and not necessarily the OEMS. Delegate Watkins M. Abbitt, Jr.'s name should be corrected. It is not Abbott. Michael Berg's name was listed on the minutes twice; remove Mike Berg from the OEMS Staff listing.	**The minutes were approved as submitted with the appropriate changes.**
Continued Discussion and Review of the Regional Council Service Areas and Proposed Changes:	Gary Critzer started the discussion by stating that at the last PAT meeting, the committee went through the objectives of the Service Area Process Action Team Charter and ranked each of those according to what was most important regarding the service delivery of the regional councils and then went through each regional council as shown on Map C. Regions A through D were discussed. The PAT now needs to look at regions E, F, and H. **REGION E** Jeff Meyer prepared a report of Region E, which according to Map C consists of the Peninsula EMS Council and the Tidewater EMS Council regions. He stated that this report is a fact sheet as it relates to patient flow, natural boundaries and regional planning. The region is divided into three areas: Northern Neck, Middle Peninsula and the Peninsula. There are two bridges which allow access to **Northern Neck**. The Norris Bridge, just south of White Stone and the Rappahannock River Bridge at Tappahannock. The primary Counties in Northern Neck are Westmoreland, Richmond, Northumberland and Lancaster. Secondary counties are King and Queen, King William and Essex. The hospital in those counties is Rappahannock General which is located in Lancaster County. It is a small rural hospital and is not part of any major health system. Riverside Tappahannock Hospital is located in Essex County. Most of the patients go to these two hospitals. Eighty-five percent of the transports of King William VRS go to Richmond hospitals; either Memorial Regional or VCU. As shown in information distributed to PAT members, for both Rappahannock General Hospital and Riverside Tappahannock Hospital, the trauma patients go to VCU. STEMI patients go to the either Memorial Regional or Henrico Doctor's Hospital and PEDS go to VCU. As for Medevac, the two primary services are LifeEvac and SkySTAT. **Middle Peninsula** consists of six counties: Mathews, Gloucester, Essex, Middlesex, King William and King and Queen. There are two bridges that allow access to the Middle Peninsula: the Rappahannock River Bridge and the Norris Bridge. The Coleman Bridge at Yorktown is the only public toll bridge in the state. The primary hospital is Riverside Walter Reed Hospital which is located in Gloucester County along Route 17. The majority of the trauma patients are transferred to Riverside Regional Medical Center and a small percentage go to Sentara Norfolk General Hospital. The STEMI patients go to Riverside Regional and PEDS go to Children's Hospital of The King's Daughters in the Tidewater region. As for Medevac, LifeEvac is the primary air medical service and Nightingale is the secondary. The **Peninsula** region consists of six jurisdictions – The cities of Poquoson, Hampton, Newport News	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	and Williamsburg and the counties of James City and York. All of the patients from these areas are transported to Riverside Regional, Mary Immaculate (Newport News), Sentara CarePlex (Hampton) or Sentara Williamsburg (western York County). The Medevac systems are primarily, Nightingale and secondarily, LifeEvac. There are two agencies which transport into the PEMS region and they are Isle of Wight into Riverside Regional and New Kent into Sentara Williamsburg. Also in the Northern Neck, Colonial Beach transports into the REMS area. Gary Critzer stated that Jeff Meyer addressed the coordination of patient flow very well. However, there needs to be an explanation of how PEMS interacts with the TEMS area in regard to emergency planning and preparedness. Both Jim Chandler and I (Jeff Meyer) sit on the MMRS Oversight Committee. Both regions do a lot of MCI planning. There is an MCI workgroup to provide an MCI guide and are currently working to merge the protocols and the purpose is because of MMRS. When there is a disaster in the Tidewater area, the agencies from the Peninsula will respond to the Tidewater area. Both regions do not want any confusion in the protocols. This is not an easy task. Meyer stated PEMS does work well with the Tidewater region and PEMS and TEMS staff meets on a quarterly basis to keep up to date with each other. When it comes to hospital diversion, the only reason a PEMS hospital goes on diversion is for a disaster or an MCI event. Bruce Edwards stated that Virginia doesn't have statewide protocols and statewide drug boxes because the system was designed that way. This can certainly be revisited and redesigned, but one of the interesting points is that there are differences in protocol use within the regions. The question that Bruce had of Jeff Meyer have is more of mechanics, Jeff mentioned MMRS, what is the perception from PEMS' standpoint on how that works? Jeff Meyer responded by saying that if there is a disaster, for example, a tornado in Suffolk, if there's a MCI event declared, MMRS would be activated. MMRS is overall regional planning. There are two separate Strike Teams one in the PEMS area and the other in the TEMS area. The PEMS team can respond to a TEMS disaster and the TEMS team to a PEMS disaster if requested. Both teams make up about 76 people. The only pitfall is the tunnels; getting to the disaster. Bruce asked Jeff how he feels about the coordination with ODEMSA. Jeff stated that there is no coordination with ODEMSA since he has been there; however, there needs to be, especially with the hurricane lane reversal evacuation plan. Jeff Meyers stated that he does not forsee a change in patient flow if the two regions were combined. His main concern is the state representation. Who will sit on the advisory board? How will one entity represent a metropolitan area and a rural area at the same time? That is his biggest concern. Tim reported that the PEMS region receives roughly 60% from OEMS. TEMS receives 19.6% of their	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	funding from OEMS. Jason Campbell asked if the Riverside Health Systems play nice together. Dr. Kaplowitz stated that the Riverside Health Systems are very competitive; but they have come a long way. They are willing to share information on bed count and other items. There was some discussion about MMRS and Connie Purvis asked "How can you say that MMRS money is super important and can take up one council's primary component of their budget and hospital money and hospital influence is not?" MMRS is disaster based and hospital emergencies take place everyday and she feels that the relationships between hospitals and EMS Councils are extremely important and should be above disaster preparedness. The PAT cannot lose sight of the fact that the system is about patient care. **REGION F** Region F, which is the Northern Virginia EMS Council region, was presented by Byron Andrews. He stated that Northern Virginia EMS Council (NVEMSC) represents nine jurisdictions. It also has 14 additional members from the private sector and hospitals and other agencies. NVEMSC represents 9 hospitals, one of which is a trauma center. There are 2.2 million people in the Northern Virginia region. NVEMSC currently have 5,000 providers and 54 licensed agencies within its borders. Last year there were a quarter of a million EMS calls. One of the roles of the EMS council is a coordinating body for each of the jurisdictions to come together to work and communicate collaboratively on issues that occur in the region. Each jurisdiction follows its own protocol and patient flow system. Jerry Overton asked if any Northern Virginia patients go to DC. Byron stated that some trauma and burn patients go to Washington, DC. About two weeks ago, an agency in Northern Virginia had about 4 firefighters go to the burn center in DC. A very small percentage of patients are transported to Mary Washington Hospital which is located in Fredericksburg. Per Byron, there have been some discussions to add Fauquier and Stafford counties to the Northern Virginia region. These are two rapidly growing counties and are going through the same things that Loudoun and Prince William counties went through 10 or 15 years ago where they were predominantly volunteer organizations. Now they are transitioning to career agencies. Tina stated that the Rappahannock EMS Council has had several meetings with Fauquier and Stafford counties as well. Stafford has indicated that they are very interested in the Northern Virginia region's disaster and preparedness planning. Stafford has had career providers since 1990; however, the board of supervisors just recently went on record noting that they will allow all the volunteer agencies to maintain their individual EMS agency licenses and recognize them as individual agencies. Apparently, Northern Virginia EMS Council has more resources than other regions such as federal funds for disaster preparedness.	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	The chiefs in Northern Virginia have indicated that by allowing Fauquier and Stafford to participate in the training activities and meetings, that if Northern Virginia were to have a major emergency or event, Fauquier and Stafford would respond or participate in the assisting with the event. While everyone thinks that Northern Virginia has a lot of resources, all of those resources were tied up when there was an ice storm in Northern Virginia in February. Northern Virginia agencies had to utilize supervisor's vehicles and fire apparatus and whatever was available to transport people to the hospital. Bruce Edwards wanted to know about the collaboration with the REMS region. Per Byron there is very little collaboration with REMS. Due to mountains separating parts of the area, there is not much collaboration. There are a very small amount of calls, say 12 to 20 that are on the border of both regions. It was asked whether Northern Virginia has regional protocols. Byron Andrews stated that they do not have regional protocols. NVEMSC is in the process of looking at commonalities so the region can have a baseline of common protocols. Dr. Scott Weir stated that the region does have an assessment protocol. Bruce Edwards asked if the drug boxes were the same. Dr. Weir stated that yes they are the same with the exception of 2 or 3 different drugs; however, each licensed provider does not have a unified drug box. Melinda Duncan wanted to clarify an earlier statement concerning Stafford & Fauquier by saying "it's a matter of resources". All of the agencies in Northern Virginia have training academies and Stafford & Fauquier goes to REMS for their basic training. Maybe eventually those agencies will have their own in-house training facilities when they get enough career people and funding to do that. But right now those agencies are in the transition process. The other part she wanted to explain was mutual aid. In the NVEMSC region it's called direct aid. It's an automatic aid that is cross-jurisdictional on a daily basis. Jason Campbell asked where the patients in Stafford County go. Byron and Tina both simultaneously answered, Mary Washington. The new hospital in Stafford will not be an INOVA hospital. It is believed that it will be a part of Mary Washington. Ray Whatley stated that being a Prince William County resident, some patients are transported to Potomac Hospital in Prince William County. Northern Virginia receives 65% of its funding from OEMS per Tim Perkins. **REGION H** Region H, which according to Map C, consists of the Thomas Jefferson EMS Council and the Rappahannock EMS Council regions were presented by Tina Skinner of REMS and Bill Downs of TJEMS. Tina stated that in terms of patient flow, the REMS region has nine localities and three hospitals. MediCorp Mary Washington Hospital is the largest health care provider and is located in	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	Fredericksburg. REMS also has Culpeper Regional and Fauquier Hospitals within its region. REMS has three new facilities currently under construction which includes Stafford Hospital; a new HCA medical center in Spotsylvania County and a new MediCorp emergency department also in Spotsylvania County. The Rappahannock Region will have a total of 6 facilities. MediCorp will be seeking to obtain a Level II Trauma Designation in September and that will be the first trauma center designation in the region. The REMS EMS system works closely and effectively with these hospitals including all the agencies that are represented. Most of the patients in the region are transported to those hospitals mentioned. There are some patients being transported to other locations, particularly in Orange County. The western part of Orange County transports the majority of their patients to UVA. The REMS council works very closely with the Rappahannock health district and with the Rapidan/Rappahannock health district but not as close. REMS works with them in terrorism coordination, disaster/emergency planning and training, and are fully integrated in this area. Most of the REMS region, as it relates to the Virginia Department of Emergency Management, Virginia State Police and Virginia Department of Fire Programs, is predominately in Division II and REMS works very closely with the coordinators of those agencies. King George and Caroline Counties are in Division I. In looking at demographics, many localities in the northern part of the region are the fastest growing in the state. The region works very closely with the military installations. There are three large military bases that participate in the EMS protocols which includes Quantico and Fort AP Hill. Also, the there are mountains which divide the region from the former federation. The region has 77 licensed EMS agencies and approximately 2,200 providers. The REMS region receives 53% of their funding from OEMS. Bill Downs of the Thomas Jefferson EMS Regional Council reported that as for patient flow, patients in eastern Louisa County, 50 % go to Richmond and the other 50% go the west to Charlottesville, either UVA or Martha Jefferson Hospital. As for Orange County, there are some crossing borders. When the federation dissolved, TJEMS made an open offer to surrounding localities to come in and "play in our back yard". Madison County took advantage of that and Orange County has played both sides of the fence. Dr. Jeffrey Alberts is a Martha Jefferson Hospital physician and is active on TJEMS's Medical Director's Committee and there has been a lot of crossover which allows for coordination and sharing of information. TJEMS is currently discussing drug box options. TJEMS has a shared program with Central Shenandoah that has been going on for years, so looking to the west there is a lot of crossover because protocols are similar. TJEMS is very fortunate to have UVA. TJEMS get funding from all of our localities, as well as a lot of support from both hospitals, and TJEMS has two full-time coordinators/educators. They provide ALS	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	CE and other programs that the council shares ownership of with the hospital. There are a lot of training and other resources that spill out of the region. The TJEMS region is at a slower growth stage than the REMS region. Gary Critzer stated that the alignment between Central Shenandoah and Thomas Jefferson would make more sense because of patient flow. The partnerships are already formed. Jason asked about patient flow of Madison County. Per Bill Downs, some go to Culpeper, but the majority goes the UVA and Martha Jefferson. Donna Burns stated that when the volunteers are working most of the patients go to Charlottesville and when the career providers are working they go to the closest facility. Some of the Nelson County patients go south to Lynchburg. Dave Cullen says he lives in the TJEMS region in the Charlottesville area, but drives to the Central Shenandoah regional office everyday and that the people are totally different to deal with from one side of the Blue Ridge Mountains to the other. Their expectations are totally different and the ability to work together in a large metropolitan area is much more difficult. Tim stated that the TJEMS region receives 60% of its funding from OEMS, which doesn't account for CTS, RSAF and Symposium, which is true for all of the council funding percentages mentioned to the PAT. Gary Critzer stated that the PAT has now heard from all of the council regions, what does the PAT do with it? Where does the committee want to go in terms of the system in Virginia in ultimately providing for the needs of the patients? Is it consolidation of regions, collaboration of regions or some combination thereof? All of the councils in Virginia deliver valuable service based on the constituents in their regions and the councils can all learn from each other. Dr. Lisa Kaplowitz announced that she will be leaving the downtown area to take on a new leadership role of Health Director in the Alexandria Health District effective July 1. She has served as the Deputy Commissioner for Emergency Preparedness and Response (EP&R) since the program began in 2002.	
Next Steps, Open Discussion:	It was decided by the committee to look at map C and provide pros and cons for their region. Tell what will and what won't work as far as Map C is concerned also show how it can be made to work. Create a plan and present the plan in a written format as well as a PowerPoint in advance of the next meeting so that the PAT committee members can have a chance to review them and be prepared to discuss them. The following people will meet and present their plans: Regions A & B – Greg Woods, Connie Purvis & Rob Logan Regions C, H & F – Dave Cullen, Tina Skinner, Bill Downs & Tracey McLaurin Region D – Tracy Thomas – may be looking at some sub-council alignments/realignments	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	Region E – Jeff Meyer & Jim Chandler Each group was appointed a facilitator/coordinator: Regions A & B – Rob Logan Regions C & H – Dave Cullen Region D – Tracy Thomas Region F – Tina Skinner Region E – Jeff Meyer Gary Brown and "Mr. No", as he is affectionately known, (Dennis Molnar) would like to see this succeed, so OEMS will allot a $2,000 budget in setting up meeting places, hotels stays, etc. Each area will need to submit travel vouchers, receipts, etc. for any expenses that are incurred.	
Public Comment Period:	None.	
Future Meeting Dates and Locations:	The next meeting will be held on Wednesday, August 20, 2008 in the Richmond area at 9:00 a.m.	
Adjournment	The meeting was adjourned at 14:00.	